Linda McCulloch, Superintendent
Office of Public Instruction
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Individualized Health Care Plan

I. IDENTIFYING INFORMATION

Student's Name		School	
Birthdate		Teacher	
Age		Grade	

CONTACTS

PARENTS

Mother's Name_____

Mother's Address_____

Mother's Home Telephone_____ Work Telephone_____ Emerg. Telephone_____

Father's Name_____

Father's Address_____

Father's Home Telephone_____ Work Telephone_____ Emerg. Telephone_____

PHYSICIAN

Physician_____ Telephone_____

Physician Address_____

HOSPITAL

Hospital Emergency Room_____ Telephone_____

Hospital Address_____

Ambulance Service_____ Telephone_____

SCHOOL

School Nurse_____ Telephone_____

II. MEDICAL OVERVIEW

Medical Condition_____ Any Known Allergies_____

Medications_____

Possible Side Effects_____

Necessary Health Care Procedures at School_____

_____

Health Care Plan for Period _____ to _____

III. OTHER IMPORTANT INFORMATION

IV. BACKGROUND INFORMATION/NURSING ASSESSMENT

Brief Medical History

☐ Check if additional information is attached.

Specific Health Care Needs

☐ Check if additional information is attached.

Social/Emotional Concerns

☐ Check if additional information is attached.

Academic Achievement

☐ Check if additional information is attached.

V. HEALTH CARE ACTION PLAN

☐ **Attach physician's order and other standards for care.**

Procedures and Interventions (student specific)

Procedure	Administered by	Equipment	Maintained by	Auth/trained by
1.				
2.				
3.				

V. HEALTH CARE ACTION PLAN (cont.)

Medications

☐ Attach medication form and administration log.

Diet

☐ Check if additional information is attached.

Transportation

☐ Check if additional information is attached.

Classroom School Modifications (including adapted PE)

☐ Check if additional information is attached.

Equipment—List necessary equipment/supplies	Provided by Parent	Provided by District
1.		
2.		
3.		
4.		

☐ None Required

Safety Measures

☐ Check if additional information is attached.

Emergency Plan ☐ Attached Transportation Plan ☐ Attached Training Plan ☐ Attached

Substitute/Backup Staff (when primary staff not available)

Possible Problems to be Expected

Training

VI. HEALTH CARE PLAN REVIEW

Next review date of Health Care Plan _____

VII. DOCUMENTATION OF PARTICIPATION

We have participated in the development of the Health Care Plan and agree with its contents.

Signature	Date	
_____		Administrator or Designee
_____		Teacher
_____		Nurse
_____		
_____		

VIII. PARENT AUTHORIZATION FOR SPECIAL HEALTH SERVICES

We (I), the undersigned who are the parents/guardians of _____ (Student Name), _____ (Birthdate) request and approve the attached Individualized Health Care Plan. We (I) understand that a qualified designated person(s) will be performing the health care service. It is our understanding that in performing this service, the designated person(s) will be using a standardized procedure which has been approved by the student's Health Care Team and Physician.

We (I) will notify the school immediately if the health status of _____ (Student Name) changes, we change physicians, or there is a change or cancellation of the procedure.

We (I) agree to provide the following, if any: medical equipment and supplies, medication, dietary supplements.

_____	_____
Parent Signature	Parent Signature
Date_____	Date_____